STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			(X3) DATE :	ETED	
		15G652	B. WING			10/19/2	011
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			90)1 JOS	DDRESS, CITY, STATE, ZIP CODE SEPH ST SBURG, IN47240		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PERCEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
K0000							
	was conducted b	ode Recertification Survey by the Indiana State Health in accordance with O(j).	K0000)			
	Survey Date: 10	0/19/11					
	Facility Number	: 001190					
	Provider Number						
	AIM Number:						
	THINT I CAME OF .	100233330					
	Surveyor: Mark Specialist	Bugni, Life Safety Code					
	not in compliant Participation in Subpart 483.470 and the 2000 edi Protection Assoc Safety Code (LS Residential Boar This one story fa sprinklered. The system with smo corridors, client common living a	Services Inc. was found be with Requirements for Medicaid, 42 CFR (j), Life Safety from Fire lition of the National Fire ciation (NFPA) 101, Life SC), Chapter 33, Existing and Care Occupancies. Accility was fully be facility has a fire alarm looke detection in the sleeping rooms and lareas. The facility has a did had a census of 5 at the					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001190

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		15G652	A. BUILDING B. WING		10/19/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE SEPH ST	
DEVELOPMENTAL SERVICES INC				NSBURG, IN47240	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	Calculation of the Score (E-Score) Alternative Appropriate Chapter 6, rated an E-Score of 0.8 Quality Review by Code Specialist-Me	e Evacuation Difficulty using NFPA 101A, roaches to Life Safety, the facility Prompt with 3. Robert Booher, Life Safety dical Surveyor on 10/25/11. found not in compliance entioned regulatory	IAU		DATE

001190

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652	(X2) MUI A. BUILD B. WING	DING	NSTRUCTION 01	(X3) DATE S COMPLE 10/19/20	ETED
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC (YALID SUMMARY STATEMENT OF DEFICIENCIES				901 JOS	DDRESS, CITY, STATE, ZIP CODE EPH ST SBURG, IN47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		P	ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX OPERATOR PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
KS053	accordance with 9 powered from the and when activate audible in all sleep are installed on all basements but excunfinished attics. A installed for living and similar spaces Exception No 1: B throughout by an a sprinkler system, i that uses quick resprinklers, and prosmoke alarms instin accordance with by the building Exception No. 2: V protected throughout automatic sprinkle with 32.3.2.5, that residential sprinkle battery-powered seping room, and the authority havin has demonstrated and a battery replate reliability of possible and a battery replate reliability of possible automatic sprinkle with 32.3.2.5, that residential sprinkle battery-powered seping room, and the authority havin has demonstrated and a battery replate reliability of possible automatic sprinkle authority havin has demonstrated and a battery replate reliability of possible authority. The following the reliability of possible authority. The following the reliability of possible authority and the reliability of possible authority. The following the reliability of possible authority authority. The following the reliability of possible authority aut	cluding crawl spaces and Additional smoke alarms are rooms, dens, day rooms, s. 33.2.3.4.3. uildings protected approved automatic in accordance with 33.2.3.5, sponse or residential otected with approved alled in each sleeping room in 9.6.2.10, that are powered electrical system. Where buildings are but by an approved in system, in accordance uses quick-response or ers, with existing moke alarms in each different where, in the opinion of an interesting in the opinion of an interesting in the string in the accordance in the opinion of an interesting in the opinion of an interesting in the opinion of an interesting in accordance in the opinion of an interesting in accordance in the opinion of an interesting in accordance in the opinion of an interesting in a control of the smoke detectors in the operation of the interesting in the operation in the o	KSO	053	This smoke detector will be relocated to meet regulations. Agency fire and security contractor will be asked to check for other area of non compliance and will make corrections as needed.	as	11/18/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

V6N821

Facility ID:

001190

If continuation sheet

Page 3 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING		ľ í	X3) DATE SURVEY COMPLETED	
15G652 B. WING				10/19/2	011		
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	-		ADDRESS, CITY, STATE, ZIP CODE		
DEVELOPMENTAL SERVICES INC					SEPH ST SBURG, IN47240		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	handling syste	ms, detectors shall			Responsible for QA: SGL		
	not be located	where airflow			Manager		
	prevents opera	ition of the					
		s deficient practice					
	affects all clier	its in the facility.					
	Findings includ	de:					
	Based on obse	rvation on					
	10/19/11 at 1						
		assistant # 1, the					
	smoke detecto	r in the client					
	sleeping room	corridor near the					
	smoke barrier	door was mounted					
		a return air supply					
	duct. This was	<u>-</u>					
		assistant # 1 at the					
	time of observ	ation.					
	I .						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652		LDING	onstruction 01	(X3) DATE COMPL 10/19/2	ETED
	PROVIDER OR SUPPLIER			901 JOS	ADDRESS, CITY, STATE, ZIP CODE SEPH ST ISBURG, IN47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) To of every resident board		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
FORM CMS-2	and care facility had all supervisory per plan for protecting of fire, for keeping evacuating persor evacuating persor necessary. The plantesponse, including needed to ensure and is amended or resident with unusual home. All employ instructed and kept their duties and replan. Such instruction to less than every plantes than every plan	as in effect and available to resonnel written copies of a of all persons in the event persons in place, for as to areas of refuge, and for as from the building when an includes special staff g fire protection procedures the safety of any resident, ar revised whenever any qual needs is admitted to the ees are periodically of informed with respect to sponsibilities under the etion is reviewed by the staff y 2 months. A copy of the ilable at all times within the 33.7.1 review and interview, the ration failed to ruct and keep employees spect to their duties and under the written not less than every 2 to 5 of 5 clients. This is a would affect all clients eviewed of the services Inc. Emergency 0/19/11 at 9:50 a.m. with asistant # 1, the services Inc. Emergency end documentation	V6N821	S147	SGL Manager will retrain QIDP's or requirements for periodic instruction for employees on the emergency action plans. QIDP's verview this information at least every other month at house meetings. Responsible for QA: SGL Manager QIDP	vill	11/18/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA	(2	01				(X3) DATE S COMPL	
AND FLAN	OF CORRECTION	15G652		. BUILDING	J	01		10/19/2	
		.0002	В	. WING	DEET APP	DECC CITY OTAT	E ZID CODE	10, 10, 2	· · ·
NAME OF P	ROVIDER OR SUPPLIER	8			1 JOSE	DRESS, CITY, STAT	E, ZIP CODE		
DEVELO	PMENTAL SERVIC	CES INC				BURG, IN47240)		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLA	N OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULI		PREI		(EACH CORRECTIVE A CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	N)	TA	G	DEFICI	ENCY)		DATE
		yees were periodically							
		ept informed with respect							
		d responsibilities under							
	the plan every tw								
	•	to present. Based on an							
		dministrative assistant # 1							
		0:00 a.m., there was no							
	other documenta								
		periodically instructed							
	_	ed with respect to their							
	_	nsibilities under the							
	_	Services Inc. Emergency							
	Action Plan after	r September 2010.							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID): V6N	821 F	acility ID:	001190	If continuation sh	eet Pac	ge 6 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/19/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
DEVELO	PMENTAL SERVIC	ES INC		SEPH ST ISBURG, IN47240	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) COMPLETION DATE	
KS152	(1) The facility hold quarterly for each varied conditions t (i) Ensure that all p trained to perform	ds evacuation drills at least shift of personnel and under o - personnel on all shifts are assigned tasks; personnel on all shifts are se of the facility's saster plans and			
	(2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.				
	paragraphs (i) (1) any live-in and reli Based on record facility failed to quarterly on 2 of	•	KS152	QIDP will retrain staff on requirements for regular evacuatic drills. A schedule will be posted in the home to ensure drills are performed as required for each shift. QIDP will review this month at house meetings to ensure compliance.	
	with administrati 10/19/11 at 9:00	w of the Fire Drill Book ve assistant # 1 on a.m., there was no st shift and third shift		Responsible for QA: QIDP	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652	(X2) MULTIPLE CO A. BUILDING B. WING	01	COM	ie survey ipleted 0/2011		
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST					
DEVELOPMENTAL SERVICES INC				NSBURG, IN47240				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	2010, or a first s for the first quar Based on an inte assistant # 1 on there was no oth	th quarter of the year hift and third shift drill ter of the year 2011. rview with administrative 10/19/11 at 9:40 a.m., er evidence available for the the missed fire drills						